Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922279	A. BUILDING: _____ B. WING _____	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF EASTBROOKE LLC	201 SUNSET DRIVE CASSELBERRY, FL 32707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (2026009971) and generator monitoring was conducted at Gardens of Eastbrooke on . The facility had deficiencies at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to follow a health care provider's order when 2 of 3 sampled Residents (#1, #2) were not given medications as prescribed. Findings: 1. Review of Resident #1's Health Assessment form (1823) revealed the resident needed assistance with self-administration of medication Review of Resident #1's record revealed on a healthcare provider ordered to	A 025		

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A 025	Continued From page 2 decrease , to 0.5 MG every hour of sleep and ordered to change dosing to 50 MG every AM, stopping second dose. Review of the Medication Observation Record (MOR) revealed on and Resident #1 received , and at both 8 AM and 5 PM. The medications were not decreased as ordered. During an interview on at 5 PM, the findings were discussed with the Director of Nursing (DON). The DON said she looked at the medication change orders today when she came in and not on Friday. During an interview on at 6:08 PM, the DON said Resident #1 continues to get , and twice a day because the pharmacy needed to put the new orders on the MOR. The DON said a paper MOR was not used to update the medication change because the paper MORs are used when the power goes out. 2. Review of Resident #2's 1823 revealed the resident needed assistance with medication self-administration Review of Resident #2's record revealed on a healthcare provider ordered to be increased to 50 MG twice a day at 8AM and 2PM. On a healthcare provider ordered , 300 MG every 8 hours. Observation on at 1:05 PM, Unlicensed Caregiver A, assisted Resident #2 with . Unlicensed Caregiver A did not follow the health care providers' order for the medication	A 025		

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A 025	Continued From page 3 to be given at 2 PM. During an interview on at 1:08 PM, the findings were discussed with Unlicensed Caregiver A. The Unlicensed Caregiver said that the medication can be given 1 hour before or 1 hour after. The Unlicensed Caregiver added, sometimes Resident #2 would ask for his medications around 1PM. The Unlicensed Caregiver said she is not sure if a healthcare provider wrote the medication order for the medication to be given at 8 AM and 2 PM or if it was done by the pharmacy. The Unlicensed Caregiver said she is not sure if the healthcare provider was informed the Resident likes to take his medication around 1 PM. During an interview on at 2:04 PM, the findings were discussed with the Director of Nursing (DON). The DON said as per the facility medication policy, the medication can be given 1 hour before and 1 hour after the time frame. The DON said the medication order from the healthcare provider did not indicate 8 AM and 2 PM and the pharmacy wrote it that way. During an interview on at 3:50 PM, the findings of the medication order of 8 AM and 2 PM were discussed with the DON. The DON said, if the medication order is not specific and does not say that the medication must be given at a certain time only then the medication policy of 1 hour before and 1 hour after is implemented. Review of Resident #2's MOR revealed that , 300 MG was scheduled and given at 8 AM, 2 PM, and 10 PM. The medication was not given every 8 hours as ordered.	A 025		

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A 025	Continued From page 4 During an interview on at 3:51 PM, the findings were discussed with the DON. During an interview on at 4:32 PM, the DON said the , should have been scheduled and given at 6 AM instead of 8 AM to reflect every 8 hours. The DON added mostly her, the Assistant Director of Nursing (ADON), and the Unlicensed Caregivers check the MORs every day. During an interview on at 5:18 PM, Unlicensed Caregiver A said she gave Resident #2 the , at approximately 9 AM today and the next time was approximately 1 PM. The Unlicensed Caregiver added that she normally gives the medication around 8 AM. Unlicensed Caregiver A said there is no reason to give at this moment why she did not give the medication as ordered for every 8 hours. During an interview on at 5:45 PM, Unlicensed Caregiver B said sometimes she would give Resident #2 his , around 6 PM because he is in around that time. The Unlicensed Caregiver said she had not informed the DON and has not documented it; she just knows the resident. During an interview on at 6:21 PM, the findings were discussed with the DON, who said that is not good. (photographic evidence obtained) Class III	A 025		